Dear Applicant:

Enclosed you will find the forms necessary for you to apply for licensure as a Respiratory Care Practitioner. It is strongly suggested that you read the Regulations prior to filling out the application, and then examine the directions entitled **"STEPS TO LICENSURE"** to see which forms are appropriate for you.

Please note the following:

(a) Applications not completed in their entirety will be returned, minus the application fee, which is non-refundable.
(b) The photograph must be a "passport photo."
(c) The name on the application must match the name on the driver's license or Social Security Card. We will not accept nicknames, abbreviations, or alterations.
(d) All fees are to be made payable to the Mississippi State Department of Health.

If you have any questions regarding the above, please contact our office as follows:

MISSISSIPPI STATE DEPARTMENT OF HEALTH
PROFESSIONAL LICENSURE-RESPIRATORY CARE
P.O. BOX 1700
JACKSON, MS 39215-1700
(601) 576-7260

Please be advised that it is illegal to practice Respiratory Care in Mississippi without being licensed or exempted by statute or regulations. Individuals engaging in such practices, or employing non-licensed practitioners, will be subject to criminal and/or civil penalties.

Sincerely,

David Kweller
Health Facilities Surveyor II

DK/bj
Enclosure

C:\My Documents\wordperfect\resppacket.wpd

TO: Applicants for Temporary Permit

FROM: David Kweller
Health Facilities Surveyor II

RE: Verification of Professional Education

Beginning immediately, the Verification of Professional Education forms, for those students who have not yet graduated, must be completed by the program director. The only Verification of Education forms that will be accepted from the registrar's office are for those individuals who have received their certificate of completion and/or degree.

STEPS TO LICENSURE
RESPIRATORY CARE PRACTITIONER

Enclosed is an application packet for a respiratory care practitioner. Two types of licences are currently issued in Mississippi: Regular and Temporary Permit. The requirements for each are as follows:

1. **Regular**

    a. Completed, notarized application.
    b. Copy of driver's license or social security card.
    c. Passport style photo
    d. Application fee - $75.00 (non-refundable).
    e. Copy of NBRC card or certificate.
    f. Copies of all licensure or registrations from other states.
    g. Verification of NBRC credential (Form 633)

2. **Temporary Permit (a 6 month license - renewal <u>once</u> for 6 months issued up to <u>one year</u> after graduation from an approved school) :**

    a. Completed, notarized application.
    b. Copy of driver's license or social security card.
    c. Passport style photo
    d. Application fee - $50.00 (non-refundable).
    e. Verification of Education form showing proof of graduation and eligibility to sit for the NBRC examination.
    f. Copies of all licensure or registrations from other states.

NOTE: Application for temporary permit can be submitted 30 days <u>prior</u> to graduation.

All requirements must be on file and satisfactory to this office before a license may be issued.

Respiratory Care

NBRC, Inc.

Credential Verification for Mississippi

To Applicant: Complete Section I below and submit it along with the required $5.00 fee for active members and $20 fee for inactive members to: National Board for Resp. Care, Inc.
8310 Nieman Road
Lenexa, Kansas 66214

To NBRC: Complete Section II below and return completed form to: Mississippi State Department of Health
Professional Licensure-Respiratory Care
P. O. Box 1700
Jackson, Mississippi 39215-1700

Section I

I am applying for state licensure in Mississippi, and I am requesting the NBRC verify my respiratory therapy credentials directly to the Mississippi State Department of Health, Branch of Professional Licensure.

I hold the following NBRC Credentials: ☐ CRTT ☐ RRT

Print name under which you were credentialed *(last, first, middle initial)*

Applicant full name (please print) *(last, first, middle initial)*	Social Security Number
Signature	Date

Section II *(for NBRC use only)*

The above named person has achieved the minimum passing score required for successful completion of an examination and earned the following NBRC credentials:

Credentials	Date Credentialed
☐ CRTT (number_____)	
☐ RRT (number_____)	
Signature	Date

Not valid unless embossed with NBRC seal *(in space below)*

Respiratory Care

Verification Of Professional Education For Licensure

Instruction To Applicant:

Upon completion of the demographic information and waiver below, this form should be signed, notarized, and forwarded to the Institution where you obtained your degree in Respiratory Care.

Date

Name (Last, First, Middle Initial)	*Maiden Name or Given Surname*
Address (Street, City, State and Zip Code)	*Phone No.* *Home* *Work* *( )* *( )*
Social Security Number	*Date of Graduation*

Waiver For The Release Of Information:

I am applying for licensure as a Respiratory Care Practitioner in the State of Mississippi. I hereby authorize the verification of my degree conferred and further authorize the release of any transcript or other information, favorable or otherwise, to the Mississippi State Department of Health, Professional Licensure – Respiratory Care, should this information be requested at any time.

_____ _____

Date *Signed*

Instructions To Educational Institution:

Upon completion of this form please send to: Mississippi State Department Of Health
Professional Licensure - Respiratory Care
P.O. Box 1700
Jackson, MS 39215-1700

Name of Institution	*Location of Institution (City&State)*
Dates of Attendance (Month/Year) From: To:	*Total Number of Academic Years*
Date Degree Conferred, or, Expected Date	*Degree Conferred, or, to be Conferred*
Program Name & Curriculum Description	

Seal of the Institution

Name

Title

Telephone Number *Date*

Respiratory Care

Application for Temporary Permit

Office Use

Check No._____

Amount $_____

Date ____/_____/____

(Please type or print in ink)

1. Date: _____

2. Name:_____
(Last) *(First)* *(Middle)*

3. Home Address:_____ 4. Telephone Number (____)_____

5. _____ 6. _____ 7. _____
(City) *(State)* *(Zip Code)* *(County)*

8. Social Security No. ☐☐☐ - ☐☐ - ☐☐☐☐ 9. Date of Birth: ☐☐ - ☐☐ - ☐☐

10. Race:_____ 11. Sex: Male ☐ Female ☐ 12. U.S. Citizen: No ☐ Yes ☐ 13. Legal Alien: No ☐ Yes ☐

14. Place of Employment:_____

15. Title of Position: _____ 16. Supervisor: _____

17. Employment Address:_____ 18. Telephone Number (____)_____

_____
(City) *(State)* *(Zip Code)* *(County)*

19. Are there any criminal or civil suits pending against you? If yes, attach a full explanation. No ☐ Yes ☐

20. Are you now addicted to or have you ever excessively used alcohol, narcotics, barbiturates or habit forming drugs? If yes, attach a full explanation. No ☐ Yes ☐

21. Have you ever been convicted of any violations of law (except minor traffic violations)? If yes, attach a full explanation. No ☐ Yes ☐

22. a. Have you ever had a license or permit encumbered in any way? No ☐ Yes ☐

b. If yes, has the decree changed? Attach a full explanation. No ☐ Yes ☐

23. Have you ever been declared mentally incompetent by any court? If yes, attach an explanation. No ☐ Yes ☐

24. a. Are you currently a student in a JRCRTE approved Respiratory Care Education Program? No ☐ Yes ☐

b. Expected date of graduation_____.

25. a. Are you now, or have you ever been licensed in another state in the area of Respiratory Care? No ☐ Yes ☐

b. If yes, what state? *(Attach a copy of license)*_____

Subscribed and sworn to before me this _____ day

of _____, 20 _____.

My commission expires_____.

I, the undersigned, do solemnly swear or affirm that I am the above applicant. I have read the above application and all statements contained therein or accompanying this application are true to the best of my knowledge and belief. I have also read and understand the Regulations Governing Licensure of Respiratory Care Practitioners and affirm that all conditions for licensure have been met and will be maintained.

_____

(Notary Public)

_____

(Applicant's Signature)

Notary Seal

Copy of Social Security Card
or
Drivers License

Photo
(only a Passport Photo will be accepted)

Complete form, enclose fee and mail to:

Mississippi State Department of Health
Professional Licensure: Respiratory Care
P. O. Box 1700
Jackson, Mississippi 39215-1700

Respiratory Care

Application for Renewal of Temporary Permit

Office Use

Check No. _____

Amount $_____

Date ___ / ___ /___

(Please type or print in ink)

Check here if change in: Name ☐ Address ☐ Telephone ☐ Employment ☐

1. License Number _____ 2. Expiration Date _____

3. Date: _____ 4. Social Security No._____

5. Name _____
(Last) *(First)* *(Middle)*

6. Home Address: _____ 7. Telephone Number (_____) _____

8. _____ 9. _____ 10. _____
(City) *(State)* *(Zip Code)* *(County)*

11. Place of Employment: _____

12. Employment Address: _____ 13. Telephone Number (_____) _____

14. _____ 15. _____ 16. _____
(City) *(State)* *(Zip Code)* *(County)*

17. a. Are you a graduate of a JRCRTE approved respiratory care program? No ☐ Yes ☐

b. Date of graduation _____

18. a. Have you taken the NBRC, Inc. examination? No ☐ Yes ☐

b. If yes, give date and location _____

19. Set forth, in detail, the reasons why a regualr license in not being applied for, and a temporary permit renewal is being requested: _____

_____

_____

_____

Subscribed and sworn to before me this _____ day

of _____, 20 _____

My commission expires _____ .

_____
(Notary Public)

I, the undersigned, do solemnly swear or affirm that I am the above applicant. I have read the above application and all statements contained therein or accompanying this application are true to the best of my knowledge and belief.

_____
(Applicant's Signature)

Notary Seal

Complete form, enclose fee and mail to:

Mississippi State Department Of Health
Professional Licensure: Resipratory Care
P. O. Box 1700
Jackson, Mississippi 39215-1700

Respiratory Care

Application for Licensure

Office Use

Check No._____

Amount $_____

Date ____/_____/____

(Please type or print in ink)

1. Date: _____

2. Name:_____
(Last) *(First)* *(Middle)*

3. Home Address:_____ 4. Telephone Number (____)_____

5. _____ 6. _____ 7. _____
(City) *(State)* *(Zip Code)* *(County)*

8. Social Security No. ☐☐☐ - ☐☐ - ☐☐☐☐ 9. Date of Birth: ☐☐ - ☐☐ - ☐☐

10. Race:_____ 11. Sex: Male ☐ Female ☐ 12. U.S. Citizen: No ☐ Yes ☐ 13. Legal Alien: No ☐ Yes ☐

14. Place of Employment:_____

15. Title of Position: _____ 16. Supervisor: _____

17. Employment Address:_____ 18. Telephone Number (____)_____

_____
(City) *(State)* *(Zip Code)* *(County)*

19. Are there any criminal or civil suits pending against you? If yes, attach a full explanation. No ☐ Yes ☐

20. Are you now addicted to or have you ever excessively used alcohol, narcotics, barbiturates or habit forming drugs? If yes attach a full explanation. No ☐ Yes ☐

21. Have you ever been convicted of any violations of law (except minor traffic violations)? If yes, attach a full explanation. No ☐ Yes ☐

22. a. Have you ever had a license or permit encumbered in any way? No ☐ Yes ☐

b. If yes, has the decree changed? Attach a full explanation. No ☐ Yes ☐

23. Have you ever been declared mentally incompetent by any court? If yes, attach an explanation. No ☐ Yes ☐

24. a. Are you currently credentialed by the National Board for Respiratory Care, Inc.? No ☐ Yes ☐

b. NBRC certification number:_____ *(attach a copy of your certification)*

25. Are you currently licensed in another state in the area of Respiratory Care? No ☐ Yes ☐

b. If yes, what state? *(Attach a copy of current license)*_____

Subscribed and sworn to before me this _____ day

of _____, 19 _____.

My commission expires_____.

I, the undersigned, do solemnly swear or affirm that I am the above applicant. I have read the above application and all statements contained therein or accompanying this application are true to the best of my knowledge and belief. I have also read and understand the Regulations Governing Licensure of Respiratory Care Practitioners and affirm that all conditions for licensure have been met and will be maintained.

_____
(Notary Public)

_____
(Applicant's Signature)

Notary Seal

Copy of Social Security Card
or
Drivers License

Complete form, enclose fee and mail to:

Mississippi State Department of Health
Professional Licensure: Respiratory Care
P. O. Box 1700
Jackson, Mississippi 39215-1700

Photo
(only a Passport Photo will be accepted)